PARENT PERMISSION FOR EDUCATIONAL ASSESSMENT

As the parent/guardian of ________________________________________, I give my permission to conduct an educational assessment for students with vision impairments to be completed by a teacher of children with visual impairments through the Educational Service Center of Northeast Ohio.

______________________________________________
Parent / Guardian Signature

______________________________________________
School District

______________________________________________
Date

The school district is to keep a copy and return the original to:

Attn: Leanne Long
Visual Impairment Program
Educational Service Center of Northeast Ohio
Essex Place
6393 Oak Tree Blvd. South
Independence, OH 44131